Medicaid Enterprise
Department of Human Services

For Human Services use only:

General Letter No. 8-AP-288
Employees' Manual, Title 8
Medicaid Appendix

August 22, 2008

REMEDIAL SERVICES MANUAL TRANSMITTAL NO. 08-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Remedial Services Manual***, Contents (page 1), new; Chapter III, *Provider-Specific Policies*, Contents (pages 1 and 2), revised; pages 1, 2, 3, 15, 17, 18, 19, 28, and 59 through 67, revised; and forms 470-4414, *Financial and Statistical Report for Remedial Services*, revised; and *Remittance Advice*, revised.

Summary

This manual is revised to:

- Clarify that when a member receiving remedial services enters a long-term institutional placement (PMIC, MHI, etc.), ISIS end-dates the authorization. Upon discharge, if remedial services continue to be appropriate for the member a new order, implementation plan, and authorization are required.
- Update the cost report form to add new Line 5000 to Schedule D for reporting of home office management fees.
- Update the instructions for CMS-1500, the *Health Insurance Claim Form*, to reflect the implementation of the national provider identifier (NPI).
- Update the *Remittance Advice* sample and instructions.

Date Effective

Upon receipt.

Material Superseded

Remove the following pages from Chapter III of the ***Remedial Services Manual*** and destroy them:

Page	Date
Contents (pp. 1, 2)	March 1, 2007
1	March 1, 2007
2	November 1, 2006
3, 15	March 1, 2007
470-4414 (after p. 16)	10/06
17-19, 28	November 1, 2006
59-69	May 1, 2007
Remittance Advice	6/12/97

Additional Information

The provider manual can be found at:

www.ime.state.ia.us/providers

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise Provider Services Unit
PO Box 36450
Des Moines, IA 50315

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to the Iowa Medicaid Enterprise Provider Services Unit.

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. PROVIDERS ELIGIBLE TO PARTICIPATE

The following providers are eligible to enroll under the category "remedial services":

- Providers that are accredited by the Mental Health, Mental Retardation, Developmental Disabilities, and Brain Injury Commission pursuant to 441 Iowa Administrative Code Chapter 24 to provide mental health services; or
- Providers that were certified by the Department as a provider of rehabilitative treatment services pursuant to 441 Iowa Administrative Code 185.10(234) as of August 31, 2006; or
- Providers that can demonstrate to the Iowa Medicaid Enterprise (IME) that they have the skills and resources to implement a member's remedial service implementation plan.

1. Enrollment

Providers eligible to participate must become enrolled with the Iowa Medicaid Enterprise. **Note:** Providers enrolled under the category "rehabilitation services for adults with chronic mental illness" before November 1, 2006, will remain enrolled as remedial services providers.

Each provider shall provide the IME Provider Services Unit with the current address of the provider's primary location and any satellite offices. It is the responsibility of the provider to contact the IME Provider Services Unit and provide an update whenever:

- There is a change of address.
- Other changes occur that affect the accuracy of the provider enrollment information.

2. Provider Requirements

As a condition of enrollment, providers of remedial services must:

- Request criminal history record information on all employees and applicants to whom an offer of employment is made, as required by Iowa Code section 135C.33(5).
- Complete a cost report, used for establishment of Medicaid reimbursement rates. (See BASIS OF PAYMENT FOR SERVICES.)

- Follow standards in 441 Iowa Administrative Code 79.3(249A) for maintenance of fiscal and clinical records. These standards pertain to **all** Medicaid providers. (See Documentation.)
- Assure that any services delivered by an individual or agency, either through employment by or a contract with the enrolled provider, shall comply with the requirements that are applicable to the enrolled provider.

B. MEMBERS ELIGIBLE TO RECEIVE SERVICES

Medicaid members may receive remedial services when they meet the following requirements, as determined by a licensed practitioner of the healing arts acting within the practitioner's scope of practice as allowed under state law:

- The member has been diagnosed with a psychological disorder. (See Diagnosis.)
- The member has a need for remedial services related to the member's psychological disorder. (See Need for Service.)

1. Diagnosis

To qualify for remedial services, a member must be diagnosed with a psychological disorder that impairs the member's independent functioning relative to primary aspects of daily living such as personal relations or living arrangements. The diagnosis (ICD-9 or DSM-IV numeric code and description) must be supportable by available documentation.

The primary diagnosis will be the diagnosis the remedial treatment plan is designed to address. Additional diagnoses are considered secondary. Information relating to a diagnosis that is over 12 months old needs to be confirmed.

A licensed practitioner of the healing arts must make the diagnosis and develop a treatment plan. The licensed practitioner must:

- Be enrolled in the Iowa Plan, and
- Be qualified to perform the clinical assessment for the purpose of establishing a diagnosis of psychological disorder under the Iowa Plan.

Clinical assessment of psychological disorders must be within the diagnosing practitioner's scope of practice under state licensing rules. Generally, this means that the practitioner's license must authorize independent practice, although the practitioner may be employed by a remedial service provider or by another organization.

Qualified practitioners currently include providers credentialed in the Iowa Plan network as physicians, advanced registered nurse practitioners, psychologists (PhD or PsyD), independent social workers, marital and family therapists, and mental health counselors.

Master's level psychologists and social workers may be included if they practice under clinical supervision in a community mental health center or have received an exception to be included in the Iowa Plan network.

2. Need for Service

A licensed practitioner of the healing arts (see Diagnosis for qualifications) must:

- Assess the member and develop a treatment plan indicating the member's need for remedial services related to the member's psychological disorder.
- Reexamine the member at least every six months (or more frequently if conditions warrant) to:
  - Evaluate the member's progress and
  - Review and approve the member's continued need for remedial services related to the member's continued diagnosis of psychological disorder.

The treatment plan will be provided to remedial services providers to use as a basis for a remedial services implementation plan. (See Remedial Services Implementation Plan.)

If the member becomes ineligible for Medicaid or enters a long-term institutional placement (PMIC, MHI, etc.), ISIS end-dates the current authorization for remedial services.

If remedial services remain appropriate upon a member's discharge from a medical institution, a licensed practitioner of the healing arts, working with the discharge planner, shall develop a new order. The practitioner completing the order may be a part of the discharge planning team or be from the medical institution.

This order and a new remedial services implementation plan should be submitted to the IME Medical Services Unit to authorize services upon the member's discharge from the medical institution. (See Service Authorization.)

Iowa Department of Human Services

FINANCIAL AND STATISTICAL REPORT FOR REMEDIAL SERVICES

PROVIDER IDENTIFICATION PAGE

AGENCY NAME _____

CITY _____

PROVIDER NO. _____

REPORT TYPE PARENT

FYE _____

RATE REFLECTED -

		Billed	Unit Cost
96152	Health and Behavior Intervention-Individual	Per 15 Min	$ 0.00
96153	Health and Behavior Intervention-Group	Per 15 Min	$ 0.00
96154	Health and Behavior Intervention-Family	Per 15 Min	$ 0.00
H0037	Community Psychiatric Supportive Treatment	Per Day	$ 0.00
H2001	Rehabilitation Program	Per Half-Day	$ 0.00
H2011	Crisis Intervention Service	Per 15 Min	$ 0.00
H2014	Skills Training and Development	Per 15 Min	$ 0.00

Iowa Department of Human Services

FINANCIAL AND STATISTICAL REPORT FOR REMEDIAL SERVICES

CERTIFICATION PAGE

AGENCY NAME 0 IRS ID#

ADDRESS PROVIDER NO. 0

CITY, STATE, ZIP CODE

PERIOD OF REPORT: From To DATE OF FISCAL YEAR END 01/00/00

ADMINISTRATOR NAME TELEPHONE NO.

NAME OF PERSON TO CONTACT IF QUESTIONS ABOUT REPORT TELEPHONE NO.

Does agency have an independent audit? ☐ Yes, for year ending ☐ No

Has a copy of the latest independent audit been submitted? ☐ Yes ☐ No

A. Type of Entity : ☐ GOVERNMENT ☐ NON-PROFIT ORGANIZATION ☐ PROPRIETARY

B. Type of Control: ☐ INDIVIDUAL ☐ PARTNERSHIP ☐ CORPORATION ☐ S CORPORATION

C. Accounting Basis : ☐ ACCRUAL ☐ MODIFIED CASH ☐ CASH

D. Statistical Data For Period of Report :

								Group Care Only	
1. Service Code	96152	96153	96154	H0037	H2001	H2011	H2014	Child Welfare Service	Group Care Maintenance
2. If subject to licensure, number of clients licensed for :									
3. No. of units of service (licensed or staffed)									
a. Type of unit (15 Min, Daily, etc)	15 Min	15 Min	15 Min	Daily	Half-Day	15 Min	15 Min	Daily	Daily
4. Total number of units of service provided									
5. Total number of units of service provided for :									
a. DHS clients									
b. Other clients									
6. Percent of units provided to unit capacity (divide line 4 by line 3)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
7. Are the rates received from non-DHS clients the same as or more than, POS rates for the same service?									
Indicate yes, or no, for each service.	yes / no	yes / no	yes / no	yes / no	yes / no	yes / no	yes / no	yes / no	yes / no

If no, explain.

E. Form of Certification by Officer or Administrator of Provider Agency:

I CERTIFY that I have examined the accompanying schedules of revenues and expenses and the calculations of cost of service prepared for this agency and that to the best of my knowledge and belief they are true and correct. I also certify these schedules were prepared from the books and records of the facility in accordance with instructions contained in this report, and allowable cost of care excludes expenses that were not necessary to provide this care.

SIGNED (Officer or Administrator of Facility)

(Title) (Date)

F. Statement of Preparer (If Other Than Agency)

I have prepared this report and to the best of my knowledge and belief, it represents true and accurate data of the agency stated above.

(Signed) (Date)

AGENCY NAME: 0
PROVIDER NO.: 0
FYE: 01/00/00
REPORT TYPE: PARENT

SCHEDULE A - REVENUE REPORT

REVENUES :	Total Revenue	Revenue for Schedule D Expense Deduction *
Fee for Service :		
Iowa State Department of Human Services	$	
County Board of Supervisors		
Private Clients		
Department of Education (Voc Rehab) (service fees only)		
United Way (service fees only)		
Social Security, SSI, SSA		
Other		
Service, Reimbursement of Investment Income :		
Work Services Revenue	$	$
Food Reimbursement (DOE)		
Investment Income		
Other (attach schedule)		
Contributions : (schedule must be attached)		
United Way : Contributions not Restricted / Appropriated	$	$
Restricted / Appropriated Contributions **		
Other : Contributions not Restricted / Appropriated		
Restricted / Appropriated Contributions **		
Government Grants :		
TOTAL REVENUE	$ 0	* $ 0

* Income which must be deducted from total service expense on Schedule D.
** Agencies must have documentation or support which identifies purpose of contributions reported as restricted / appropriated.

470-4414 (08/08)

AGENCY NAME: 0 FYE: 01/00/00

PROVIDER NO.: 0 REPORT TYPE: PARENT

SCHEDULE B - STAFF GROSS SALARIES AND STAFF NUMBERS

JOB CLASSIFICATIONS:	NUMBER OF STAFF Full Time	Part Time	FTE's	GROSS SALARIES AND WAGES
ADMINISTRATIVE - NO. 2110				
Title:				
ADMINISTRATIVE TOTAL - NO. 2110	**0**	**0**	**0.00**	**$ 0**
PROFESSIONAL - NO. 2120				
Title:				
PROFESSIONAL TOTAL - NO. 2120	**0**	**0**	**0.00**	**$ 0**
DIRECT CLIENT CARE - NO. 2130				
Title:				
DIRECT CLIENT CARE TOTAL - NO. 2130	**0**	**0**	**0.00**	**$ 0**
CLERICAL - NO. 2150				
Title:				
CLERICAL TOTAL - NO. 2150	**0**	**0**	**0.00**	**$ 0**
OTHER STAFF - NO. 2190				
Title:				
OTHER STAFF TOTAL - NO. 2190	**0**	**0**	**0.00**	**$ 0**
TOTAL SALARIES & STAFF NUMBERS	**0**	**0**	**0.00**	**$ 0**

AGENCY NAME: 0
PROVIDER NO.: 0
FYE: 01/00/00
REPORT TYPE: PARENT

SCHEDULE C - DEPRECIATION AND AMORTIZATION EXPENSE

	ACCT NO. (Schedule D)	YEAR ACQUIRED	ORIGINAL COST	DEPREC. RECORDED PRIOR YEAR	DEPREC. METHOD	ANNUAL RATE	RECORDED DEPREC. EXPENSE
EQUIPMENT:							
BUILDING EQUIPMENT	4420						
1.					SL		$ 0
2.					SL		$ 0
3.					SL		$ 0
4.					SL		$ 0
5.					SL		$ 0
6.					SL		$ 0
7.					SL		$ 0
DEPARTMENTAL EQUIPMENT	4420						
1.					SL		$ 0
2.					SL		$ 0
3.					SL		$ 0
4.					SL		$ 0
5.					SL		$ 0
6.					SL		$ 0
7.					SL		$ 0
OTHER EQUIPMENT	4420						
1.					SL		$ 0
2.					SL		$ 0
3.					SL		$ 0
4.					SL		$ 0
5.					SL		$ 0
6.					SL		$ 0
7.					SL		$ 0
OFFICE FURNITURE & FIXTURES	4420						
1.					SL		$ 0
2.					SL		$ 0
3.					SL		$ 0
4.					SL		$ 0
5.					SL		$ 0
6.					SL		$ 0
7.					SL		$ 0
OTHER	4420						
1.					SL		$ 0
2.					SL		$ 0
3.					SL		$ 0
4.					SL		$ 0
5.					SL		$ 0
6.					SL		$ 0
7.					SL		$ 0
SUBTOTAL EQUIPMENT	4420		**$ 0**			To Schedule D, line 4420	**$ 0**

SCHEDULE C - DEPRECIATION AND AMORTIZATION EXPENSE

	ACCT NO. (Schedule D)	YEAR ACQUIRED	ORIGINAL COST	DEPREC. RECORDED PRIOR YEAR	DEPREC. METHOD	ANNUAL RATE	RECORDED DEPREC. EXPENSE
MOTOR VEHICLES:	4410						
1.					SL		$ 0
2.					SL		$ 0
3.					SL		$ 0
4.					SL		$ 0
5.					SL		$ 0
6.					SL		$ 0
SUBTOTAL VEHICLES	4410		**$ 0**			To Schedule D, line 4410	**$ 0**
TOTAL EQUIPMENT							

	ACCT NO. (Schedule D)	YEAR ACQUIRED	ORIGINAL COST	DEPREC. RECORDED PRIOR YEAR	DEPREC. METHOD	ANNUAL RATE	RECORDED DEPREC. EXPENSE
BUILDINGS:							
BUILDINGS	4480						
1.					SL		$ 0
2.					SL		$ 0
3.					SL		$ 0
4.					SL		$ 0
5.					SL		$ 0
6.					SL		$ 0
7.					SL		$ 0
ADDITIONS	4480						
1.					SL		$ 0
2.					SL		$ 0
3.					SL		$ 0
4.					SL		$ 0
5.					SL		$ 0
6.					SL		$ 0
7.					SL		$ 0
LEASEHOLD IMPROVEMENTS	4480						
1.					SL		$ 0
2.					SL		$ 0
3.					SL		$ 0
4.					SL		$ 0
5.					SL		$ 0
OTHER							
1.					SL		$ 0
2.					SL		$ 0
3.					SL		$ 0
4.					SL		$ 0
TOTAL BUILDINGS & LEASEHOLDS	4480		**$ 0**			To Schedule D, line 4480	**$ 0**

TOTAL EQUIPMENT & BUILDINGS	4400		**$ 0**			To Schedule D, line 4400	**$ 0**

SCHEDULE C - DEPRECIATION AND AMORTIZATION EXPENSE

RELATED PARTY PROPERTY COSTS

1. Is any property being leased from a party "related to provider" using the definitions in the contract and the Provider Handbook?

   Yes _____ No _____

2. SCHEDULE OF LESSOR'S COSTS :

   If answer to number 1 is yes, provide lessor's costs in the space below.

Depreciation on property	
Property taxes	
Mortgage interest on property	
Insurance	
Other (describe)	
	0.00
TOTAL	$

AGENCY NAME: 0
PROVIDER NO.: 0
FYE: 01/00/00
REPORT TYPE: PARENT

SCHEDULE D - EXPENSE REPORT

ACCOUNT NO.	TITLE	Gross Total	Revenue Adjust	Excluded Costs	Adjusted Costs	96152 Health Behavior Intervention Individual	96153 Health Behavior Intervention Group	96154 Health Behavior Intervention Family	H0037 Community Psych Support Daily
2110	Administrative	$ 0			$ 0				
2120	Professional Staff - Direct	$ 0			$ 0				
2130	Other - Direct	$ 0			$ 0				
2150	Clerical	$ 0			$ 0				
2190	Other Staff	$ 0			$ 0				
2100	**TOTAL SALARIES**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
2210	Health Benefits				$ 0				
2220	Retirement Plan				$ 0				
2290	Other Benefits				$ 0				
2200	**TOTAL BENEFITS**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
2310	FICA Expense				$ 0				
2320	Unemployment				$ 0				
2350	Workmen's Compensation				$ 0				
2300	**TOTAL PAYROLL TAXES**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
2450	Medical & Psych Services Purchased				$ 0				
2470	Accounting and Auditing				$ 0				
2480	Attorney's Fees				$ 0				
2490	Other Non-Medical				$ 0				
2400	**TOTAL PROFESSIONAL FEES**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
2510	Office Supplies				$ 0				
2530	Medical Supplies				$ 0				
2540	Recreation & Craft Supplies				$ 0				
2550	Food				$ 0				
2590	Other Supplies				$ 0				
2500	**TOTAL SUPPLIES**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
2600	**TELEPHONE & INTERNET**				**$ 0**				
2700	**POSTAGE & SHIPPING**				**$ 0**				

SCHEDULE D - EXPENSE REPORT

ACCOUNT NO.	TITLE	Gross Total	Revenue Adjust	Excluded Costs	Adjusted Costs	96152 Health Behavior Intervention Individual	96153 Health Behavior Intervention Group	96154 Health Behavior Intervention Family	H0037 Community Psych Support Daily
2810	Rent of Space				$ 0				
2820	Building & Grounds Supplies				$ 0				
2830	Utilities				$ 0				
2840	Care of Buildings & Grounds				$ 0				
2870	Interest Expense				$ 0				
2880	Insurance & Property Taxes				$ 0				
2890	Other Occupancy Expense				$ 0				
2800	**TOTAL OCCUPANCY EXPENSE**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
3100	**OUTSIDE PRTG - ART WORK**				**$ 0**				
3210	Mileage & Auto Rental				$ 0				
3250	Agency Vehicles Expense				$ 0				
3280	Automobile Insurance				$ 0				
3290	Other Related Transportation				$ 0				
3200	**TOTAL LOCAL TRANS.**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
3310	Staff Development & Training				$ 0				
3320	Annual Meetings & Bus. Conference				$ 0				
3300	**TOTAL CONF. & CONVENTIONS**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
3400	**SUBSCRIPTIONS/PUBLICS.**				**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
3510	Clothing & Personal Needs				$ 0				
3520	Other				$ 0				
3500	**TOTAL ASSISTANCE**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
4100	**ORGANIZATION DUES**				**$ 0**				
4200	**AWARDS & DUES**				**$ 0**				

SCHEDULE D - EXPENSE REPORT

ACCOUNT NO.	TITLE	Gross Total	Revenue Adjust*	Excluded Costs	Adjusted Costs	96152 Health Behavior Intervention Individual	96153 Health Behavior Intervention Group	96154 Health Behavior Intervention Family	H0037 Community Psych Support Daily
4310	Agency Vehicle Repair				$ 0				
4320	Other Equipment Repair or Purchase				$ 0				
4300	**REPAIRS & EXPENDABLE EQUIP.**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
4410	Agency Vehicles	$ 0			$ 0				
4420	Equipment	$ 0			$ 0				
4480	Buildings and Leaseholds	$ 0			$ 0				
4400	**TOTAL DEPRECIATION**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
4910	Moving & Recruitment				$ 0				
4920	Liability Insurance				$ 0				
4930	Miscellaneous				$ 0				
4900	**TOTAL MISCELLANEOUS**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
5000	**HOME OFFICE & MANAGEMENT FEE**				**$ 0**				
	TOTAL EXPENSES	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**

DESCRIPTION	Gross Total	Revenue Adjust	Excluded Costs	Adjusted Costs	96152 Health Behavior Intervention Individual	96153 Health Behavior Intervention Group	96154 Health Behavior Intervention Family	H0037 Community Psych Support Daily
TOTAL EXPENSES	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
ALLOCATION OF INDIRECT PROGRAM SERVICE COSTS					**$ 0**	**$ 0**	**$ 0**	**$ 0**
TOTAL SERVICE OR MAINTENANCE COSTS AFTER ALLOCATION OF INDIRECT					$ 0	$ 0	$ 0	$ 0
* PROGRAM INCOME OR REIMBURSEMENTS								
* UNITED WAY CONTRIBUTIONS								
* OTHER CONTRIBUTIONS								
* GOVERNMENT GRANTS								
TOTAL SERVICE OR MAINTENANCE COSTS AFTER DEDUCTIONS					$ 0	$ 0	$ 0	$ 0
UNITS OF SERVICE					**0**	**0**	**0**	**0**
UNIT COST **					**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 0.00**

* Deductions from Schedule A

AGENCY NAME: 0
PROVIDER NO.: 0
FYE: 01/00/00
REPORT TYPE: PARENT

SCHEDULE D - EXPENSE REPORT

ACCOUNT NO.	TITLE	H2001 Rehab Program	H2011 Crisis Intervention Service	H2014 Skills Training And Development	*From Supplemental Sch. D-1* Child Welfare Service Daily	Group Care Maint. Daily	Other Programs	Total Facility Indirect Service Costs
2110	Administrative				$ 0	$ 0		
2120	Professional Staff - Direct				$ 0	$ 0		
2130	Other - Direct				$ 0	$ 0		
2150	Clerical				$ 0	$ 0		
2190	Other Staff				$ 0	$ 0		
2100	**TOTAL SALARIES**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
2210	Health Benefits				$ 0	$ 0		
2220	Retirement Plan				$ 0	$ 0		
2290	Other Benefits				$ 0	$ 0		
2200	**TOTAL BENEFITS**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
2310	FICA Expense				$ 0	$ 0		
2320	Unemployment				$ 0	$ 0		
2350	Workmen's Compensation				$ 0	$ 0		
2300	**TOTAL PAYROLL TAXES**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
2450	Medical & Psych Services Purchased				$ 0	$ 0		
2470	Accounting and Auditing				$ 0	$ 0		
2480	Attorney's Fees				$ 0	$ 0		
2490	Other Non-Medical				$ 0	$ 0		
2400	**TOTAL PROFESSIONAL FEES**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
2510	Office Supplies				$ 0	$ 0		
2530	Medical Supplies				$ 0	$ 0		
2540	Recreation & Craft Supplies				$ 0	$ 0		
2550	Food				$ 0	$ 0		
2590	Other Supplies				$ 0	$ 0		
2500	**TOTAL SUPPLIES**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
2600	**TELEPHONE & INTERNET**				**$ 0**	**$ 0**		
2700	**POSTAGE & SHIPPING**				**$ 0**	**$ 0**		

SCHEDULE D - EXPENSE REPORT

ACCOUNT NO.	TITLE	H2001 Rehab Program	H2011 Crisis Intervention Service	H2014 Skills Training And Development	*From Supplemental Sch. D-1* Child Welfare Service Daily	Group Care Maint. Daily	Other Programs	Total Facility Indirect Service Costs
2810	Rent of Space				$ 0	$ 0		
2820	Building & Grounds Supplies				$ 0	$ 0		
2830	Utilities				$ 0	$ 0		
2840	Care of Buildings & Grounds				$ 0	$ 0		
2870	Interest Expense				$ 0	$ 0		
2880	Insurance & Property Taxes				$ 0	$ 0		
2890	Other Occupancy Expense				$ 0	$ 0		
2800	**TOTAL OCCUPANCY EXPENSE**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
3100	**OUTSIDE PRTG - ART WORK**				**$ 0**	**$ 0**		
3210	Mileage & Auto Rental				$ 0	$ 0		
3250	Agency Vehicles Expense				$ 0	$ 0		
3280	Automobile Insurance				$ 0	$ 0		
3290	Other Related Transportation				$ 0	$ 0		
3200	**TOTAL LOCAL TRANS.**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
3310	Staff Development & Training				$ 0	$ 0		
3320	Annual Meetings & Bus. Conference				$ 0	$ 0		
3300	**TOTAL CONF. & CONVENTIONS**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
3400	**SUBSCRIPTIONS/PUBLICS.**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**		
3510	Clothing & Personal Needs				$ 0	$ 0		
3520	Other				$ 0	$ 0		
3500	**TOTAL ASSISTANCE**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
4100	**ORGANIZATION DUES**				**$ 0**	**$ 0**		
4200	**AWARDS & DUES**				**$ 0**	**$ 0**		

SCHEDULE D - EXPENSE REPORT

ACCOUNT NO.	TITLE	H2001 Rehab Program	H2011 Crisis Intervention Service	H2014 Skills Training And Development	*From Supplemental Sch. D-1* Child Welfare Service Daily	Group Care Maint. Daily	Other Programs	Total Facility Indirect Service Costs
4310	Agency Vehicle Repair				$ 0	$ 0		
4320	Other Equipment Repair or Purchase				$ 0	$ 0		
4300	**REPAIRS & EXPENDABLE EQUIP.**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
4410	Agency Vehicles				$ 0	$ 0		
4420	Equipment				$ 0	$ 0		
4480	Buildings and Leaseholds				$ 0	$ 0		
4400	**TOTAL DEPRECIATION**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
4910	Moving & Recruitment				$ 0	$ 0		
4920	Liability Insurance				$ 0	$ 0		
4930	Miscellaneous				$ 0	$ 0		
4900	**TOTAL MISCELLANEOUS**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
5000	**HOME OFFICE & MANAGEMENT FE**				**$ 0**	**$ 0**		
	TOTAL EXPENSES	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**

DESCRIPTION	H2001 Rehab Program	H2011 Crisis Intervention Service	H2014 Skills Training And Development	*From Supplemental Sch. D-1* Child Welfare Service Daily	Group Care Maint. Daily	Other Programs	Total Facility Indirect Service Costs
TOTAL EXPENSES	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
ALLOCATION OF INDIRECT PROGRAM SERV	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	
TOTAL SERVICE OR MAINTENANCE COSTS /	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	
* PROGRAM INCOME OR REIMBURSEMENTS							
* UNITED WAY CONTRIBUTIONS							
* OTHER CONTRIBUTIONS							
* GOVERNMENT GRANTS							
TOTAL SERVICE OR MAINTENANCE COST	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	
UNITS OF SERVICE	**0**	**0**	**0**	**0**	**0**		
UNIT COST **	**$ 0.00**	**$ 0.00**	**$ 0.00**				

* Deductions from Schedule A

AGENCY NAME: 0
PROVIDER NO.: 0
FYE: 01/00/00
REPORT TYPE: PARENT

SUPPLEMENTAL SCHEDULE D-1
GROUP CARE EXPENSE REPORT

ACCOUNT NO.	TITLE	Service D160	Maintenance D190	Service D260	Maintenance D290	Service D360	Maintenance D390	Service D460	Maintenance D490	Total Child Welfare Service Daily	Total Daily Maintenance Cost
2110	Administrative									$ 0	$ 0
2120	Professional Staff - Direct									$ 0	$ 0
2130	Other - Direct									$ 0	$ 0
2150	Clerical									$ 0	$ 0
2190	Other Staff									$ 0	$ 0
2100	**TOTAL SALARIES**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
2210	Health Benefits									$ 0	$ 0
2220	Retirement Plan									$ 0	$ 0
2290	Other Benefits									$ 0	$ 0
2200	**TOTAL BENEFITS**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
2310	FICA Expense									$ 0	$ 0
2320	Unemployment									$ 0	$ 0
2350	Workmen's Compensation									$ 0	$ 0
2300	**TOTAL PAYROLL TAXES**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
2450	Medical & Psych Services Purchased									$ 0	$ 0
2470	Accounting and Auditing									$ 0	$ 0
2480	Attorney's Fees									$ 0	$ 0
2490	Other Non-Medical									$ 0	$ 0
2400	**TOTAL PROFESSIONAL FEES**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
2510	Office Supplies									$ 0	$ 0
2530	Medical Supplies									$ 0	$ 0
2540	Recreation & Craft Supplies									$ 0	$ 0
2550	Food									$ 0	$ 0
2590	Other Supplies									$ 0	$ 0
2500	**TOTAL SUPPLIES**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
2600	**TELEPHONE & INTERNET**									**$ 0**	**$ 0**
2700	**POSTAGE & SHIPPING**									**$ 0**	**$ 0**
2810	Rent of Space									$ 0	$ 0
2820	Building & Grounds Supplies									$ 0	$ 0
2830	Utilities									$ 0	$ 0
2840	Care of Buildings & Grounds									$ 0	$ 0
2870	Interest Expense									$ 0	$ 0
2880	Insurance & Property Taxes									$ 0	$ 0
2890	Other Occupancy Expense									$ 0	$ 0
2800	**TOTAL OCCUPANCY EXPENSE**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
3100	**OUTSIDE PRTG - ART WORK**									**$ 0**	**$ 0**
3210	Mileage & Auto Rental									$ 0	$ 0
3250	Agency Vehicles Expense									$ 0	$ 0
3280	Automobile Insurance									$ 0	$ 0
3290	Other Related Transportation									$ 0	$ 0
3200	**TOTAL LOCAL TRANS.**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
3310	Staff Development & Training									$ 0	$ 0
3320	Annual Meetings & Bus. Conference									$ 0	$ 0
3300	**TOTAL CONF. & CONVENTIONS**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**

ACCOUNT NO.	TITLE	Service D160	Maintenance D190	Service D260	Maintenance D290	Service D360	Maintenance D390	Service D460	Maintenance D490	Total Child Welfare Service Daily	Total Daily Maintenance Cost
3400	**SUBSCRIPTIONS/PUBLICS.**									**$ 0**	**$ 0**
3510	Clothing & Personal Needs									$ 0	$ 0
3520	Other									$ 0	$ 0
3500	**TOTAL ASSISTANCE**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
4100	**ORGANIZATION DUES**									**$ 0**	**$ 0**
4200	**AWARDS & DUES**									**$ 0**	**$ 0**
4310	Agency Vehicle Repair									$ 0	$ 0
4320	Other Equipment Repair or Purchase									$ 0	$ 0
4300	**REPAIRS & EXPENDABLE EQUIP.**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
4410	Agency Vehicles									$ 0	$ 0
4420	Equipment									$ 0	$ 0
4480	Buildings and Leaseholds									$ 0	$ 0
4400	**TOTAL DEPRECIATION**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
4910	Moving & Recruitment									$ 0	$ 0
4920	Liability Insurance									$ 0	$ 0
4930	Miscellaneous									$ 0	$ 0
4900	**TOTAL MISCELLANEOUS**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
5000	**HOME OFFICE & MANAGEMENT FEES**									**$ 0**	**$ 0**
	TOTAL EXPENSES	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**

DESCRIPTION	Service D160	Maintenance D190	Service D260	Maintenance D290	Service D360	Maintenance D390	Service D460	Maintenance D490	Total Child Welfare Service Daily	Total Daily Maintenance Cost
TOTAL EXPENSES	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
ALLOCATION OF INDIRECT PROGRAM SERVICE COSTS	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**	**$ 0**
TOTAL SERVICE OR MAINTENANCE COSTS AFTER INDIRECT ALLOCATION	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
* PROGRAM INCOME OR REIMBURSEMENTS									$ 0	$ 0
* UNITED WAY CONTRIBUTIONS									$ 0	$ 0
* OTHER CONTRIBUTIONS									$ 0	$ 0
* GOVERNMENT GRANTS									$ 0	$ 0
TOTAL SERVICE OR MAINTENANCE COSTS AFTER DEDUCTIONS	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
UNITS OF SERVICE									**0**	**0**
UNIT COST	**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 0.00**

* Deductions from Schedule A

Provider Agency: 0
Report Type PARENT
Period of Report: 01/00/00 to 01/00/00

SCHEDULE E - COMPARATIVE BALANCE SHEET

ASSETS, LIABILITIES AND EQUITY

	Balance At End Of	
	Current Period	Prior Period
ASSETS:		
Cash $		
Receivable from Clients		
Receivable from Others		
Property and Equipment:		
Land		
Buildings and Equipment		
Less Allowance for Depreciation		
Net Property and Equipment	$0.00	$0.00
Investments and Other Assets		
TOTAL ASSETS $	$0.00	$0.00
LIABILITIES AND EQUITY:		
Accounts Payable $		
Accrued Taxes (Payroll and Property)		
Other Liabilities		
Notes and Mortgages		
TOTAL LIABILITIES		
Equity or Fund Balance		
TOTAL LIABILITIES AND EQUITY $	$0.00	$0.00

RECONCILIATION OF EQUITY OR FUND BALANCE

TOTAL EQUITY OR FUND BALANCE BEGINNING OF PERIOD $		
Add:		
TOTAL REVENUE from Schedule A		
Other Revenue. Explain.		
Deduct:		
TOTAL EXPENSES from Schedule D		
Other Expenses. Explain.		
TOTAL EQUITY OR FUND BALANCE END OF PERIOD $	$0.00	$0.00

Provider Agency: 0
Report Type: PARENT
Period of Report: 01/00/00 to 01/00/00

SCHEDULE F - COST ALLOCATION PROCEDURES

(To be completed by Providers which offer more than one service)

Cost are allocable to a particular service, such as a grant, project, or other activity, in accordance with the relative benefits received. A cost is allocable to a service if it is treated consistently with other costs incurred for the purpose in like circumstances, and if it (1) is incurred specifically for the service, (2) benefits the service and can be distributed in reasonable proportion to the benefits received and (3) is necessary to the overall operation of the organization, although a direct relationship to a particular service cannot be shown.

Any cost allocable to a particular service under the above principles may not be shifted to other services to overcome funding deficiencies, or to avoid other restrictions imposed by law or terms of an award or program.

Direct Costs:	YES	NO
1. Do you have a cost allocation plan which describes the methods you use in distributing joint costs to services or activities?	☐	☐

2. What is your method for allocating joint cost? Attach supporting documentation

	YES	NO
3. If you do not have a cost allocation plan describing the methods followed, do you have accounting workpapers available to support joint direct cost allocations?	☐	☐
4. Is your method of allocating joint service costs consistently followed from year to year?	☐	☐
5. Are costs allocated to services in reasonable proportion to benefits received?	☐	☐
6. Are service income deductions allocated in a manner which is consistent with the costs incurred in generating the income?	☐	☐

7. Additional comments regarding allocation of joint service costs:

Indirect Costs:	YES	NO
1. Are the indirect costs distributed on a basis of total direct service or costs?	☐	☐

2. If indirect costs are not allocated on the basis of total direct service costs, what was the basis used? Attach supporting documentation.

	YES	NO
3. Is the basis for distributing indirect cost the same as that used in the previous year?	☐	☐

Provider Agency: 0
Report Type: PARENT
Period of Report: 01/00/00 to 01/00/00

SCHEDULE G: SUPPLEMENTAL ALLOCATION REPORT, PART I

A	B	C	D	E	F	G	
Account Number	Account Title	Allowable		Total	Allocation of Total Costs to:		Basis of
		Direct Costs	Indirect Costs	Costs	Maintenance	CW Service	Allocation
from 2190	Food Service & Maintenance Workers Salaries			0			Definintion
% of 2200	Food Service & Maintenance Workers Benefits			0			Definintion
% of 2300	Food Service & Maintenance Workers Payroll Taxes			0			Definintion
2130	Direct Care Staff Salaries			0			Time Study
% of 2200	Direct Care Staff Benefits			0			Time Study
% of 2300	Direct Care Staff Payroll Taxes			0			Time Study
from 2120	Other Direct Staff(Pgm Supv/SW-Thpst/Nurse)			0			Time Study
% of 2200	Other Direct Staff Benefits			0			Time Study
% of 2300	Other Direct Staff Payroll Taxes			0			Time Study
% of 2110	Other Admin Staff(Clinical/Pgm Supy of Mgr) Salaries			0			Time Study
% of 2200	Clerical Supervisor Benefits			0			Time Study
% of 2300	Clerical Supervisor Payroll Taxes			0			Time Study
2450	Medical and Psychological Purchased Services			0			Definintion
2490	Other Non-Medical Services Purchased			0			Definintion
2530	Medical Supplies			0			Definintion
2540	Recreation("Family-like") & Craft Supplies			0			Definintion
2480	Formalized Non "Family-like" recreation			0			Definintion
2550	Food			0			Definintion
3510+3520	Clothing, Personal Needs, School Supplies & Other			0			Definintion
2810	Rent of Space			0			Sq. Ft. - Use
2820	Building and Ground Supplies			0			Sq. Ft. - Use
2830	Utilities			0			Sq. Ft. - Use
2840	Care of Buildings and Grounds			0			Sq. Ft. - Use
2870	Interest of Buildings and Grounds			0			Sq. Ft. - Use
2880	Insurance and Property Taxes			0			Sq. Ft. - Use
2890	Other Occupancy Expenses			0			Sq. Ft. - Use
	TOTALS	**0**	**0**	**0**	**0**	**0**	
		Service/Maintenance Percentages			**0.00%**	**0.00%**	

Provider Agency: 0
Report Type: PARENT
Period of Report: 01/00/00 to 01/00/00

SCHEDULE G: SUPPLEMENTAL ALLOCATION REPORT, PART II

Residual Cost NOT included in Schedule G, Part I	
Remainder of Program Direct Costs *(Total Program Schedule D Direct - Part I Direct)* :	0.00
Remainder of Program Indirect Costs *(Total Program Schedule D Indirect - Part I Indirect)* :	0.00
Part II Totals:	**0.00**

UNIT COST DETERMINATION:	
Maintenance:	
MAINTENANCE PERCENTAGE FROM SCHEDULE G PART I	0.00%
TOTAL PART 2 MAINTENANCE COST	0.00
TOTAL MAINTENANCE COST FROM PART I	0.00
GRAND TOTAL MAINTENANCE COSTS	0.00
DEDUCTIONS FROM MAINTENANCE COST FROM SCHEDULE D	0.00
GRAND TOTAL MAINTENANCE COSTS AFTER DEDUCTIONS	**0.00**
Child Welfare Service:	
CHILD WELFARE SERVICE PRECENTAGE FROM SCHEDULE G PART I	0.00%
TOTAL PART II CHILD WELFARE SERVICE COST	0.00
TOTAL CHILD WELFARE SERVICE COST FROM PART I	0.00
GRAND TOTAL CHILD WELFARE SERVICE COSTS	0.00
DEDUCTIONS FROM CHILD WELFARE SERVICE COST FROM SCHEDULE D	0.00
GRAND TOTAL CHILD WELFARE SERVICE COST AFTER DEDUCTIONS	**0.00**

Provider Agency: 0
Report Type: PARENT
Period of Report: 01/00/00 to 01/00/00

Allocation of Staff Time Worksheet

Type of Staff: _____

(Use Separate form for each type of staff type, i.e.- Administrative, Professional, Direct Care, Supervisors, etc.)

Enter Percent of Time Spent on Maintenance Activities:	_____	Line 1
Enter Percent of Time Spent on Child Welfare Service Activities:	_____	Line 2
Enter Percent of Time Spent on Medicaid RSP Activities:	_____	Line 3
Enter Percent of Time Spent on Administrative Activities:	_____	Line 4
Enter Percent of Time Spent on Activities for Other Programs:	_____	Line 5
Total	_____	Line 6

Add Lines 1, 2, 3 and 5:	_____	Line 7
Divide Line 1 by Line 7:	_____	Line 8
Divide Line 2 by Line 7:	_____	Line 9
Divide Line 3 by Line 7:	_____	Line 10
Divide Line 5 by Line 7:	_____	Line 11

Multiply Line 4 by Line 8: (This is the percentage of administrative time allocated to maintenance)	_____	Line 12
Multiply Line 4 by Line 9: (This is the percentage of administrative time allocated to Child Welfare Service)	_____	Line 13
Multiply Line 4 by Line 10: (This is the percentage of administrative time allocated to Medicaid RSP)	_____	Line 14
Multiply Line 4 by Line 11: (This is the percentage of administrative time allocated to Other Programs)	_____	Line 15

Add Line 1 and Line 12: (This is the total percentage of time allocated to maintenance. Use this percentage to allocate staff cost to maintenance.)	_____	Line 16
Add Line 2 and Line 13: (This is the total percentage of time allocated to service. Use this percentage to allocate staff cost to service.)	_____	Line 17
Add Line 3 and Line 14: (This is the total percentage of time allocated to RSP. Use this percentage to allocate staff cost to service.)	_____	Line 18
Add Line 5 and Line 15: (This is the total percentage of time allocated to Other Programs. Use this percentage to allocate staff cost to service.)	_____	Line 19

** The combined percent of time spent on Maintenance, Child Welfare Service, Medicaid Service , Administrative and Other Program Activities should total 100%*

For purposes of Medicaid-payable services, OMB guidelines for depreciation and amortization reimbursement apply. It is the Iowa Department of Human Services' policy to allow a three-year write-off of computer equipment and software programs.

OMB Circular #A-87 reflects financing costs (including interest) paid or incurred on or after September 1, 1995, associated with building acquisition, construction, fabrication, reconstruction, or remodeling completed on or after October 1, 1980, as allowable. Financing costs (including interest) paid or incurred on and after September 1, 1995, for operating purposes are also allowable.

Allowable costs will be limited to those costs that are considered reasonable, necessary, and related to the service provided to the member.

"Reasonable cost" for purposes of Medicaid-payable services is defined as that amount of cost or expense that would ordinarily be incurred by similar providers in similar markets. It is that level of cost which a prudent and cost conscious buyer of goods and services is ordinarily willing to incur in providing these kinds of services.

2. Submission of Cost Reports

Remedial services providers shall submit their cost reports using form 470-4414, *Financial and Statistical Report for Remedial Services*. To view a sample of this form on line, click here.

Providers may obtain form 470-4414 by contacting IME Provider Cost Audit and Rate Setting Unit. The cost report is available either electronically in Microsoft Excel software or as hard copy. Electronic versions of the cost report can be found at the following IME links:

- Non-consolidated: http://www.ime.state.ia.us/docs/RSPCostReport.xls
- Consolidated (parent): http://www.ime.state.ia.us/docs/RSPCostReportParent.xls

New providers not having historical costs may complete the report using projected costs. Only the certification page, Schedule D, and Schedule F of form 470-4414 are required.

You may submit your cost reports electronically via e-mail to: costaudit@dhs.state.ia.us. Sending the cost report electronically allows the Provider Audits and Rate Setting Unit to begin processing the desk review of the cost report sooner.

a. Identification Page

Fill in the top five lines. For "Report type," enter either "Projected" or "Actual." Enter the FYE (fiscal year end) as MM/DD/YY (e.g., 06/30/01).

The purpose of the certification page is to report agency statistical information and record the signature of the authorized officer of the agency. You must complete every item on this page.

Agency Name and **Address:** Enter the official name and address of your agency. Generally, this is the name and address that appears on the license or official agency letterhead.

IRS ID No.: Enter the number assigned the facility for federal tax purposes (federal withholding, etc.).

Provider No.: Enter the Medicaid provider number assigned to your agency at certification. (**Note:** If you have multiple provider numbers, you must prepare a separate cost report for each number and also a "parent" cost report for the entire agency.)

Period of Report: Enter the dates for which the current information is being provided.

Date of Fiscal Year End: Enter the ending date for your fiscal year.

Names and **Telephone Numbers:** Self-explanatory.

Audit: Indicate if your agency had a certified public accounting firm perform an audit of its financial statements. Forward a copy of the latest independent audit to the Department when available.

Type of Entity and **Type of Control:** Indicate the ownership and control under which your agency is conducted.

Accounting Basis: Indicate the basis on which you keep your books.

- Accrual: Record revenue when earned and expenses when incurred.
- Modified Cash: Combination of cash and accrual methods.
- Cash: Record revenue when received and expenses when paid.

The accrual basis is the required method for the purpose of establishing rates and determining settlements based on actual cost. If you do not use the accrual basis of accounting, you **must** adjust reported amounts to the accrual basis. Keep the accounting work papers used in adjusting your records from cash to accrual.

Statistical Data: Enter the number of units provided under each procedure code during the reporting period. Include all units of service provided, regardless of whether payment has been received.

"Billable time" means direct face-to-face contact with the member. For half-day units, the basis of a unit is determined to be at least three hours of direct face-to-face contact with the member. For unit rounding guidelines, refer to PROCEDURE CODES AND NOMENCLATURE.

Signatures: Signatures are required as follows:

- **Item E:** "The Officer or Administrator of Facility" should be the person at the agency who is ultimately responsible for the content of the report.
- **Item F:** "Statement of Preparer (If Other than Agency)" should be signed by the person who actually prepared the report.

b. Schedule A

The purpose of Schedule A, "Revenue Report," is to report total agency income and the income allocated to the specific services and programs. Report all revenues, including those from other programs.

Report the total revenues or gross income in the column headed "Total Revenue." Revenue categories are provided on the schedule for the most common sources. If additional categories are necessary, submit accompanying schedules.

Revenues are generally broken down into three classifications for purposes of completing this report:

- **Fees for services** represent income earned through performing services to or for members. Third parties might pay the fees on behalf of members for which services were performed.

- **Other income** includes program revenues from:
  - The sale of products,
  - Food reimbursements from the Department of Education, and
  - Investment income that is not from restricted or appropriated contributions and is held separate and not commingled with other funds.

  Additional other income items may be applicable. If so, identify them accordingly or support them by an accompanying schedule.

- **Contributions** include all United Way funding, other donations, and government grants that are not designated as fees for services. When reporting income from contributions, you must also submit a schedule showing the contribution and its anticipated designation. Report the contributions as "restricted" or "appropriated" as follows:
  - **Restricted or appropriated:** Include funds that are either appropriated by the provider through formal board action or restricted by the donor. This includes interest from the contribution, when this interest is also restricted or appropriated and is held separate and not commingled with other funds.
  - **Not restricted or appropriated:** Include donations that are not appropriated or designated by the provider through board action or restriction by the donor.
  - **Government grants:** Government grants should be explained on an accompanying schedule that sets forth the source of funding, the purpose and the period of the grant, and the program to which the grant pertains.

Note: Income generated from agency activities not directly related to the provision of member service and from restricted or appropriated contributions should be reflected on Schedule D as a reduction of related expense (i.e. interest income should be offset to the extent of related interest expense). Report this reduction either in Column 2 of Schedule D or on the last page of Schedule D. Report each deduction only once.

Expenses other than wages and fringe benefits can be charged as direct service expense if they are identifiable to a specific service.

Examples of non-billable direct costs include:

- Mileage costs for travel necessary in the provision of service.
- Time spent documenting services provided.
- Time spent in staff meetings related to a particular member or remedial service.

Show indirect costs in Column 15 **only**. Do not include indirect costs in Columns 5-14.

Indirect Service Costs (Column 15): This column should include those service and administrative expenses that cannot be directly related to any specific service or program. These costs will be allocated across all programs and services after all other costs have been apportioned.

Indirect costs after adjustments for revenue and expense should be shown in column 15. Some examples of indirect administrative cost are:

- Staff development and training
- Receptionist position
- Office supplies
- Telephone
- Rent for administrative offices
- Property or liability insurance

To the extent possible, itemize your indirect costs by line item or account. All line items may be used as appropriate to report indirect costs in column 15.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** No entry required.
14.	DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY	**SITUATIONAL** Enter the date of the onset of treatment in MM/DD/YY format. For pregnancy, use the date of the last menstrual period (LMP) as the first date. This field is not required for preventative care.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS...	**SITUATIONAL** Required for chiropractors only. Chiropractors must enter the current x-ray date in MM/DD/YY format.
16.	DATES PATIENT UNABLE TO WORK...	**OPTIONAL** No entry required.
17.	NAME OF REFERRING PROVIDER OR OTHER SOURCE	**SITUATIONAL** Required if the referring provider is not enrolled as an Iowa Medicaid provider. "Referring provider" is defined as the healthcare provider that directed the patient to your office.
17a.		**LEAVE BLANK**. The claim will be returned if any information is entered in this field.
17b.	NPI	**SITUATIONAL** ♦ If the patient is a MediPASS member and the MediPASS provider authorized service, enter the 10-digit NPI of the referring provider. ♦ If this claim is for consultation, independent laboratory services, or medical equipment, enter the NPI of the referring or prescribing provider. ♦ If the patient is on lock-in and the lock-in provider authorized the service, enter the NPI of the authorizing provider.
18.	HOSPITALIZATION DATES RELATED TO...	**OPTIONAL** No entry required.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
19.	RESERVED FOR LOCAL USE	**OPTIONAL** No entry required. Note that pregnancy is now indicated with a pregnancy diagnosis code in box 21. If you are unable to use a pregnancy diagnosis code in any of the fields in box 21, write in this box "Y – Pregnant."
20.	OUTSIDE LAB	**OPTIONAL** No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	**REQUIRED** Indicate the applicable ICD-9-CM diagnosis codes in order of importance to a maximum of four diagnoses (1-primary, 2-secondary, 3-tertiary, and 4-quaternary). Do **not** enter descriptions. If the patient is pregnant, one of the diagnosis codes must indicate pregnancy. The pregnancy diagnosis codes are as follows: 640 through 648, 670 through 677, V22, V23
22.	MEDICAID RESUBMISSION CODE...	This field will be required at a future date. Instructions will be provided before the requirement is implemented.
23.	PRIOR AUTHORIZATION NUMBER	**SITUATIONAL** If there is a prior authorization, enter the prior authorization number. Obtain the number from the prior authorization form.
24. A	DATE(S) OF SERVICE/NDC	
	TOP SHADED PORTION	**SITUATIONAL** Required for provider-administered drugs. Enter qualifier "N4" followed by the NDC for the drug referenced in 24d (HCPCs). No spaces or symbols should be used in reporting this information.
	LOWER PORTION	**REQUIRED** Enter the month, day, and year under both the "From" and "To" categories for each procedure, service or supply. If the "From-To" dates span more than one calendar month, enter each month on a separate line. Because eligibility is approved on a month-by-month basis, spanning or overlapping billing months could cause the entire claim to be denied.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
24. B	PLACE OF SERVICE	**REQUIRED** Using the chart below, enter the number corresponding to the place service was provided. Do **not** use alphabetic characters. 11 Office 12 Home 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room – hospital 24 Ambulatory surgical center 25 Birthing center 26 Military treatment facility 31 Skilled nursing 32 Nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water 51 Inpatient psychiatric facility 52 Psychiatric facility – partial hospitalization 53 Community mental health center 54 Intermediate care facility/mentally retarded 55 Residential substance abuse treatment facility 56 Psychiatric residential treatment center 61 Comprehensive inpatient rehabilitation facility 62 Comprehensive outpatient rehabilitation facility 65 End-stage renal disease treatment 71 State or local public health clinic 81 Independent laboratory 99 Other unlisted facility
24. C	EMG	**OPTIONAL** No entry required.
24. D	PROCEDURES, SERVICES OR SUPPLIES	**REQUIRED** Enter the codes for each of the dates of service. **Do not** list services for which no fees were charged. Do **not** enter descriptions. Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code or valid Current Procedural Terminology (CPT) codes. When applicable, show HCPCS code modifiers with the HCPCS code.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
24. E	DIAGNOSIS POINTER	**REQUIRED** Indicate the corresponding diagnosis code from field 21 by entering the number of its position, e.g., 3. **Do not** write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.
24. F	$ CHARGES	**REQUIRED** Enter the usual and customary charge for each line item. The charge must include both dollars and cents.
24. G	DAYS OR UNITS	**REQUIRED** Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the **total minutes** of general anesthesia.
24. H	EPSDT/FAMILY PLANNING	**SITUATIONAL** Enter an "F" if the services on this claim line are for family planning. Enter an "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24. I	ID QUAL.	**LEAVE BLANK**
24. J	RENDERING PROVIDER ID # TOP SHADED PORTION LOWER PORTION	 **LEAVE BLANK** **REQUIRED** Enter the NPI of the provider rendering the service when the NPI given in field 33a does not identify the treating provider.
25.	FEDERAL TAX ID NUMBER	**OPTIONAL** No entry required.
26.	PATIENT'S ACCOUNT NUMBER	**FOR PROVIDER USE** Enter the account number you have assigned to the patient. This field is limited to 10 alpha/numeric characters.
27.	ACCEPT ASSIGNMENT	**OPTIONAL** No entry required.
28.	TOTAL CLAIM CHARGE	**REQUIRED** Enter the total of the line item charges. If more than one claim form is used to bill services performed, total each claim form separately. Do not carry over any charges to another claim form.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
29.	AMOUNT PAID	**SITUATIONAL** Required if the member has other insurance and the insurance has made a payment on the claim. Enter only the amount paid by the other insurance. Do not list member copayments, Medicare payments, or previous Medicaid payments on this claim. Do not submit this claim until you receive a payment or denial from the other carrier. Proof of denial must be kept in the patient record.
30.	BALANCE DUE	**REQUIRED** Enter the amount of total charges less the amount entered in field 29.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	**REQUIRED** Enter the signature of either the provider or the provider's authorized representative and the original filing date. The signatory must be someone who can legally attest to the service provided and can bind the organization to the declarations on the back of this form. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	SERVICE FACILITY LOCATION INFORMATION	**REQUIRED** Enter complete address of the treating or rendering provider.
32a.	NPI	**OPTIONAL** Enter the NPI of the facility where services were rendered.
32b.		**LEAVE BLANK**
33.	BILLING PROVIDER INFO AND PHONE #	**REQUIRED** Enter the name and complete address of the billing provider. **Note:** The address must contain the ZIP code associated with the billing provider's NPI. The ZIP code must match the ZIP code confirmed during NPI verification. To view the confirmed ZIP code, visit imeservices.org.
33a.	NPI	**REQUIRED** Enter the 10-digit NPI of the billing provider.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
33b.		**REQUIRED** Enter "ZZ" followed by the taxonomy code associated with the billing provider's NPI. No spaces or symbols should be used. The taxonomy code must match the taxonomy code confirmed during NPI verification. To view the confirmed taxonomy code, return to imeservices.org.

H. REMITTANCE ADVICE

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting. To view a sample of this form on line, click here.

1. Remittance Advice Explanation

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied, and suspended claims.

- **Paid** indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.
- **Denied** represents all processed claims for which no reimbursement is made.
- **Suspended** reflects claims which are currently in process pending resolution of one or more issues (member eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount.

IAMC8000-R001 (CP-O-12)
AS OF 10/22/07

IOWA DEPARTMENT OF HUMAN SERVICES
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 10/19/07

R E M I T T A N C E A D V I C E

TO: (1) R.A. NO.: 3(2)6 WARR NO.: 9(3)9 DATE PAID: 10/22/07 (4) PROV. NUMBER: (5) PAGE: (6) 1

**** PATIENT NAME **** LAST	FIRST MI	RECIP ID / LINE	TRANS-CONTROL-NUMBER / SVC-DATE	PROC/MODS	UNITS	BILLED AMT.	OTHER SOURCES	PAID BY MCAID	COPAY AMT.	MED RCD NUM / PERF. PROV.	S	EOB	EOB
* * * CLAIM TYPE: HCFA 1500 (7)								* * * CLAIM STATUS: PAID (8)					
ORIGINAL CLAIMS: (9)			(11)			(12)	(13)	(14)	(15)	(16)			(17)
		(10)	3-07290-00-015-0941-00		(21)	172.00	0.00	85.07	1.00				000 000
		(18) 01	(19) 10/04/07	99242 (20)	1	172.00	(22)	85.07 (24)	1.00 (25)	(26)		F	000 000
							(23)						
			3-07292-00-009-0053-00			69.00	0.00	32.36	0.00	(27)			000 000
		01	07/06/07	99212	1	69.00		32.36	0.00			F	000 000
			3-07288-00-010-0484-00			298.00	0.00	145.03	0.00				000 000
		01	07/11/07	99212 25	1	69.00		32.36	0.00			F	000 000
		02	07/11/07	29405	1	197.00		112.67	0.00			F	000 000
		03	07/11/07	A4590	1	32.00		0.00	0.00			K	177 000
			0-07281-22-009-0270-00			128.00	0.00	71.46	0.00				000 000
		01	06/14/07	20550	1	122.00		68.06	0.00			F	000 000
		02	06/14/07	J3301	2	6.00		3.40	0.00			F	000 000
4 CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS..						667.00	0.00	333.92	1.00				

An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a "2" in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the IME Provider Services Unit with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

2. Remittance Advice Field Descriptions

NO.	FIELD NAME	DESCRIPTION
1.	To:	Billing provider's name as specified on the Medicaid Provider Enrollment Application.
2.	R.A. No.:	Remittance Advice number.
3.	Warr No.:	The sequence number on the check issued to pay this claim.
4.	Date Paid:	Date claim paid.
5.	Prov. Number:	Billing provider's Medicaid (Title XIX) number.
6.	Page:	*Remittance Advice* page number.

NO.	FIELD NAME	DESCRIPTION
7.	Claim Type:	Type of claim used to bill Medicaid.
8.	Claim Status:	Status of following claims: • **Paid**. Claims for which reimbursement is being made. • **Denied**. Claims for which no reimbursement is being made. • **Suspended**. Claims in process. These claims have not yet been paid or denied.
9.	Patient Name	Member's last and first name.
10.	Recip ID	Member's Medicaid (Title XIX) number.
11.	Trans-Control-Number	Transaction control number assigned to each claim by the IME. Please use this number when making claim inquiries.
12.	Billed Amt.	Total charges submitted by provider.
13.	Other Sources	Total amount applied to this claim from other resources, i.e., other insurance or spenddown.
14.	Paid by Mcaid	Total amount of Medicaid reimbursement as allowed for this claim.
15.	Copay Amt.	Total amount of member copayment deducted from this claim.
16.	Med Recd Num	Medical record number as assigned by provider; 10 characters are printable.
17.	EOB	Explanation of benefits code for informational purposes or to explain why a claim denied. Refer to the end of the *Remittance Advice* for explanation of the EOB code.
18.	Line	Line item number.
19.	SVC-Date	The first date of service for the billed procedure.
20.	Proc/Mods	The procedure code for the rendered service.
21.	Units	The number of units of rendered service.
22.	Billed Amt.	Charge submitted by provider for line item.

NO.	FIELD NAME	DESCRIPTION
23.	Other Sources	Amount applied to this line item from other resources, i.e., other insurance, spenddown.
24.	Paid by Mcaid	Amount of Medicaid reimbursement as allowed for this line item.
25.	Copay Amt.	Amount of member copayment deducted for this line item.
26.	Perf. Prov.	Treating provider's Medicaid (Title XIX) number.
27.	S	Allowed charge source code: **B** Billed charge **F** Fee schedule **M** Manually priced **N** Provider charge rate **P** Group therapy **Q** EPSDT total screen over 17 years **R** EPSDT total under 18 years **S** EPSDT partial over 17 years **T** EPSDT partial under 18 years **U** Gynecology fee **V** Obstetrics fee **W** Child fee
28.	Remittance totals	(Found at the end of the *Remittance Advice*): • Number of paid original claims, the amount billed by the provider, and the amount allowed and reimbursed by Medicaid. • Number of paid adjusted claims, amount billed by the provider, and the amount allowed and reimbursed by Medicaid. • Number of denied original claims and the amount billed by the provider. • Number of denied adjusted claims and the amount billed by the provider. • Number of pended claims (in process) and the amount billed by the provider. • Amount of the check (warrant) written to pay these claims.
29.	Description of EOB code	Lists the individual explanation of benefits codes used, followed by the meaning of the code and advice.